SOUTH DAKOTA
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Breast-feeding in South Dakota

by Melissa Berg, RD, LN, WIC Nutrition Consultant, Department of Health

Breast-feeding has long been recognized as the ideal method for infant feeding, but due to recent scientific advances in research methods there is an increased knowledge of the benefits and underlying mechanisms for the benefits of breast-feeding. In February 2005, the American Academy of Pediatrics released an updated Policy Statement on Breast-feeding and the Use of Human Milk that cites substantial research to support the importance and health impacts of breastfeeding for both mothers and infants. The policy statement is available on the American Academy of Pediatrics website at www.aappolicy.aappublications.org.

Breast milk provides the infant with the right proportion of nutrients that are needed for growth and development. It also provides antibodies which help to reduce the incidence of diseases and illnesses, especially diarrhea, respiratory tract infections, otitis media, and urinary tract infections. Breast-feeding has also been shown to decrease the incidence of adult and childhood obesity and slightly increase performance on cognitive development tests. The longer an infant is breastfed the more benefits are provided to the infant. Breast-feeding an infant during a painful procedure such as an immunization provides an analgesic to the infant.

Because breast-fed infants are usually healthier than formula fed infants, there are also economic benefits to breast-feeding that include fewer visits to the doctor due to illness and fewer days of employee absenteeism to take care of a sick infant. The community and environment also benefit from the decreased need for formula cans and bottles.

Breast-feeding has also been shown to improve maternal health by helping women return more quickly to their pre- pregnancy weight and decreasing their risk of premenopausal breast cancer and osteoporosis.

To promote the importance of breast-feeding, National Healthy People 2010 Goals have been established by the U.S. Department Health and Human Services.

SOUTH DAKOTA BREAST-FEEDING RATES			
	Healthy People 2010 Goal	**South Dakota WIC Program 2003**	**South Dakota Infants 2004**
Breast-fed in early postpartum period	75%	55.9%	68.7%
Breast-fed to at least 6 months	50%	22%	NA
Breast-fed until 1 year	25%	13.1%	NA

Source: South Dakota Department of Health

Since 1999, the South Dakota Department of Health has used the Newborn Metabolic Screening Program's laboratory form to collect information on breast-feeding initiation for all infants born in South Dakota. Annually, the statewide and individual hospital data are provided to each birthing hospital to track breast-feeding rates.

While South Dakota's breast-feeding initiation rates are on track to meet the Healthy People 2010 goal, there is still work to be done to increase the duration rates. South Dakota has the highest percentage of working mothers in the country which has an impact on women's ability to breast-feed after they return to work and/or school.

In 2004 the federal WIC Reauthorization Bill designated money for states to implement or improve a Breast-feeding Peer Counselor program. South Dakota submitted a proposal and received a grant to train three breast-feeding peer counselors. The goal of this program is to increase the number of women who choose to breast-feed their infants and also increase the length of time these women breast-feed their infants. The three WIC agencies that were selected to be pilot sites for this breast-feeding peer counselor program are Beadle, Brookings and Butte (Belle Fourche) Counties. Breast-feeding peer counselors are now in place and working with pregnant and breast-feeding WIC mothers in these local agencies.

More information about breast-feeding can be found on the Department of Health web site, http://www.state.sd.us/doh/Nutrition.

Pertussis increase in South Dakota

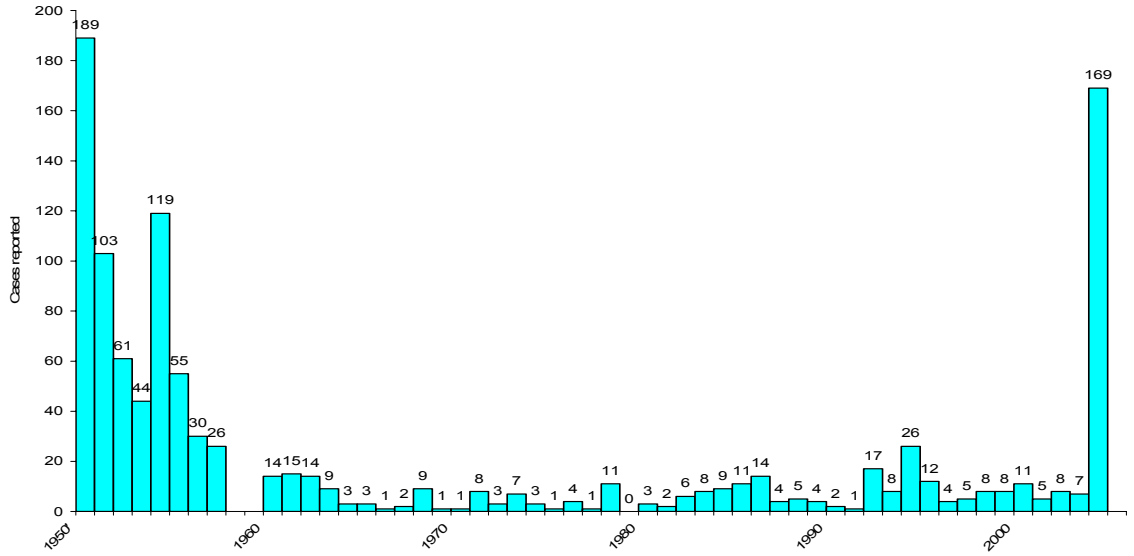
During 2004, 169 cases of pertussis were reported in South Dakota, the highest number since 1950. By the end of September, 2005 South Dakota had reported 129 cases.

Pertussis, commonly called whooping cough, is an acute infectious bacterial disease caused by *Bordetella pertussis*. The bacteria produce toxins that inflame and paralyze respiratory cilia causing severe coughing. Pertussis is transmitted by aerosolized droplets of respiratory secretions from infected individuals.

In the first half of the twentieth century pertussis was a common childhood disease and major cause of death. In the 1930's South Dakota averaged 480 pertussis cases reported annually. The pertussis vaccine became available in the 1940's, reducing the incidence of the disease. Since 1950 South Dakota has had a median of 8 cases per year. During 2004, 169 (22.2 cases per 100,000 population) cases of pertussis were reported in South Dakota. This compares to 7 cases reported in 2003. No deaths were reported due to pertussis complications. In the United States

25,827 pertussis cases were reported in 2004, a 122% increase over 2003 when 11,647 cases of pertussis were reported. States with the highest incidence of pertussis in 2004 (cases per 100,000 population were North Dakota 119, Wisconsin 102, Iowa 36, Vermont 29, Minnesota 27, Massachusetts 26, Colorado 26 and South Dakota 22.

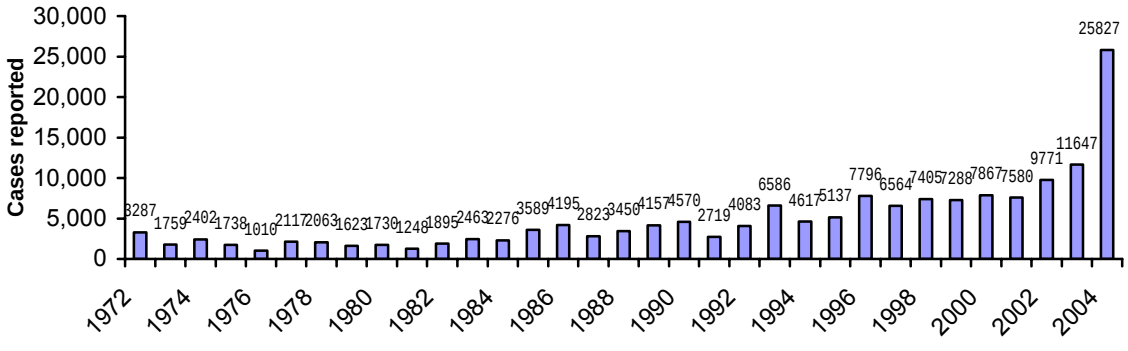
Pertussis cases reported in South Dakota, 1950 – 2004. (no data for 1958 and 1959)



In addition to the 169 cases, 1,935 individuals were identified as direct contacts to cases or suspect cases. Individuals who are direct, exposed contacts should receive antibiotic prophylaxis, and if they are symptomatic or suspected of having pertussis, they are recommended for diagnostic testing, isolated and not allowed to attend day care, school or work until 5 days after treatment.

Pertussis cases were reported from 31 of 66 South Dakota counties during 2004. The counties with the most cases include Roberts County with 31 cases reported, Pennington County 14 cases, Todd 14 cases, Hand 13 cases, Corson and Walworth 10 cases each. The map on the next page shows the incidence of pertussis by county.

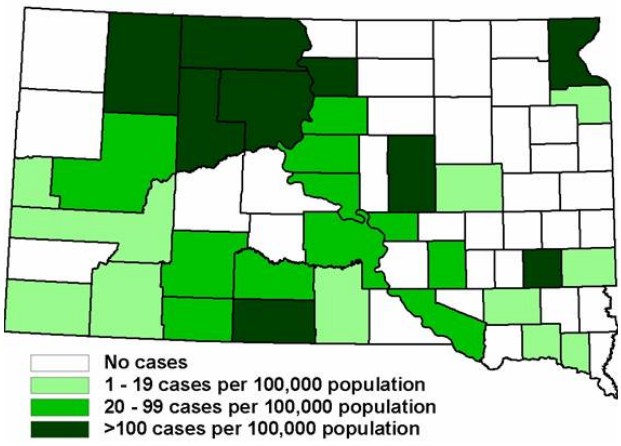
Pertussis cases, United States, 1972 – 2004



Infants and young children are at higher risk of pertussis-associated complications, hospitalization and death. The most common complication is secondary bacterial pneumonia. Twelve percent of pertussis cases reported were among infants less than 12-months old, 25% of cases were five years old or younger, and 50% were 13 years old and younger. Pertussis

infected youth and adults may expose unprotected infants who are at risk of severe disease and complications. Among the 2004 South Dakota pertussis cases 43% of infants <12 months old developed pneumonia and 60% of infants were hospitalized.

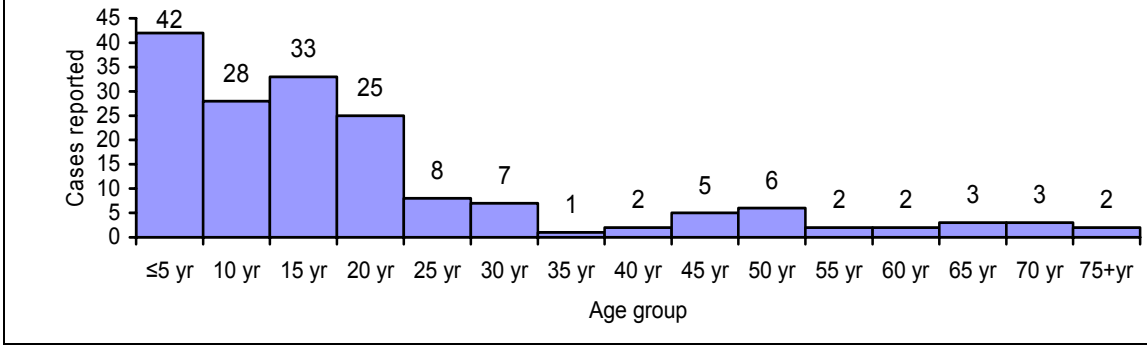
Pertussis Incidence Rates by County, South Dakota, 2004



Immunization is the best protection for infants and young children. The current pertussis vaccine is an acellular purified, inactivated vaccine (DTaP) licensed only for children 6 years and younger. The primary series of DTaP consists of four doses. The first 3 doses are given when the child is 2, 4 and 6 months old, and the fourth dose given when the child is 15-18 months old. A fifth booster dose should be given when the child is 4 – 6 years old, before entering school. In 2004 no pertussis vaccine was licensed for persons 7 years and older in the United States. This has changed in 2005 with the licensing of adult and adolescent pertussis vaccines.

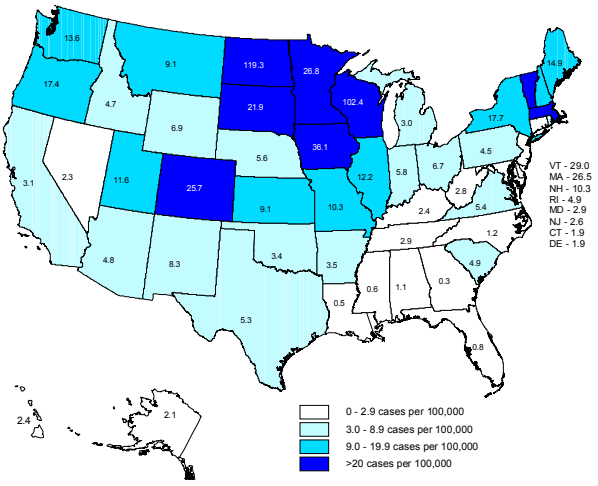
The current pertussis vaccine has a reported efficacy of 80% - 85%. Immunity conferred by either vaccination or natural infection wanes over time. Although unvaccinated children are at highest risk for pertussis, children who are fully vaccinated may also develop disease. Pertussis in previously immunized children is usually milder than in unvaccinated children.

Age group of pertussis cases, South Dakota, 2004.



Of the 169 cases of pertussis reported, 62 were vaccine eligible children between the ages of 2 months and 10 years old. Eight cases were among infants less than two months old who were too young to be vaccinated. Of these 62 children 66% were age-appropriately immunized for pertussis, while 34% were not appropriately immunized. In the youngest children, of the 33 cases in children 7 months to 7 years of age, 6 (18%) received less than three doses of pertussis vaccine before onset of illness. These cases are considered preventable cases.

Pertussis incidence USA, 2004
(cases per 100,000 population)



The diagnostic gold standard for pertussis is a positive culture result for *Bordetella pertussis.* The preferred specimen is a nasopharyngeal aspirate or a nasopharyngeal swab. Throat or anterior nasal specimens are unacceptable. Molecular polymerase chain reaction (PCR) testing of nasopharyngeal specimens is available at the SD Public Health Laboratory. The PCR method is more sensitive than the traditional culture method and is likely responsible in part for more cases reported in 2004. The direct fluorescent antibody (DFA) stain of a nasopharyngeal swab is unreliable, so this test cannot be used to confirm pertussis. Serologic testing is not acceptable for clinical diagnosis.

PERTUSSIS CONTROL MEASURES

- **IMMUNIZATION:** Child immunization records should be checked and the child vaccinated if they are behind. Pertussis vaccinations (DTaP) should be given at 2, 4, 6 and 15-18 months; and children 4–6 years old should be given a 5th pertussis immunization. The protection of pertussis immunization wanes after time, making teenagers and adults susceptible, even if they were immunized as children. Two new pertussis vaccines received FDA license in mid-2005: Boostrix® for children 10-18 years old and ADACEL™ for individuals 11-64 years of age.

- **AWARENESS**: Pertussis should be considered when evaluating any infant, child, or adult with an acute cough illness characterized by prolonged cough or cough with paroxysms, whoop, or post-tussive gagging/vomiting. Infants may present with apnea and/or cyanosis.

- **DIAGNOSIS:** Unvaccinated infants may have a marked lymphocytosis indicative of pertussis, but the diagnostic gold standard for pertussis is a positive culture result for *Bordetella pertussis*. The preferred specimen is a nasopharyngeal aspirate; however, a nasopharyngeal swab (Dacron) may also be used. Swabs or aspirate must be placed in Regan-Lowe transport media if direct inoculation of selective media is not possible (Regan-Lowe media is available at the SD Public Health Laboratory). Throat or anterior nasal specimens are unacceptable. PCR testing of nasopharyngeal specimens is available at the SD Public Health Laboratory. The direct fluorescent antibody (DFA) stain of a nasopharyngeal swab is unreliable, so this test cannot be used to confirm pertussis. Serologic testing is not acceptable for clinical diagnosis. Please call the Public Health Laboratory with questions 1-800-592-1861.

- **EXPOSURE and CONTACTS:** All exposed persons should receive antibiotic prophylaxis, even if they are fully vaccinated children. Exposure is defined as face-to-face contact with a coughing pertussis case; or direct contact with respiratory, oral, or nasal secretions; or shared confined space in close proximity for a prolonged period of time, such as 1 hour, with a symptomatic case-patient. When exposed individuals are identified in the community the Department of Health recommends that all contacts see their own physician for evaluation and prophylaxis. After exposure the incubation period for pertussis averages 9-10 days, but ranges from 6-20 days.

HOSPITAL PRECAUTIONS: Hospitalized patients with known or suspected pertussis should be placed in respiratory isolation (droplet precautions) for at least the first 5 days of antimicrobial treatment. Exposed health care workers should be queried daily for at least 21 days after exposure about possible pertussis symptoms. Persons with symptoms should be excluded from work and allowed to return when they are well, another diagnosis is established, or they have been on appropriate antimicrobial treatment for 5 days.

- **ISOLATION:** Symptomatic patients should be excluded from daycare, school and work, and refrain from contact outside the household for the first 5 days of antibiotic treatment, or for 21 days if they do not take prophylactic antibiotics.

- **TREATMENT and PROPHYLAXIS**: Erythromycin is the drug of choice for treatment and prophylaxis. If erythromycin is not tolerated, azithromycin, clarithromycin or trimethoprim-sulfamethoxazole may be used as alternatives, although their efficacies are unknown.

Antibiotic	Children	Adults
Erythromycin: drug of choice. (Some authorities prefer the estolate preparation for children, but recommend avoiding its use in adults.)	40-50 mg/kg/day, orally, in 4 divided doses for 14 days (max of 2 g/day)	1-2 grams/day, orally, in 4 divided doses for 14 days (max of 2 g/day)
Clarithromycin [Biaxin] : (Not recommended for use in infants <2 months old or pregnant women)	15-20 mg/kg/day, orally, in 2 divided doses for 7 days (max 1 g/day)	500 mg orally 2 times/day for 7 days
Azithromycin [Zithromax, Z-Pak] (Not recommended for infants <6 mo old)	10-12 mg/kg/day, orally, in 1 dose for 5 days, max 500 mg/day. Or Z-Pak: Day one, 10 mg/kg orally (max 500 mg/day). Days 2-5, 5 mg/kg, orally (max 250 mg/day)	500 mg/day, orally, for 5-7 days. Or Z-Pak: 500 mg/day, orally, first day; then 250 mg/day for days 2-5.
Trimethoprim-sulfamethoxazole [Bactrim, Septra]: (Not recommended for infants <2 months old or pregnant women)	Trimethoprim 8 mg/kg/day, sulfamethoxazole 40 mg/kg/day, orally, in 2 divided doses for 14 days	Trimethoprim 320 mg/day, sulfamethoxazole 1,600 mg/day, orally, in 2 divided doses for 14 days

- **REPORTING:** Pertussis is a Category I Reportable Disease in South Dakota. Please report known or suspected cases promptly to the Department of Health, 1-800-592-1861.

- **RESOURCES**: Detailed information on treatment, diagnosis and control:

  - CDC's "Guidelines for the Control of Pertussis Outbreaks" found at www.cdc.gov/health/pertussis.htm (The Department of Health will send you a hard copy of this manual, if you wish. Call 1-800-592-1861.)

  - Red Book 2003, p 472-486, (American Academy of Pediatrics Report of the Committee on Infectious Diseases).

  - Whooping cough fact sheet is found at www.state.sd.us/doh/Pubs/pertuss.htm

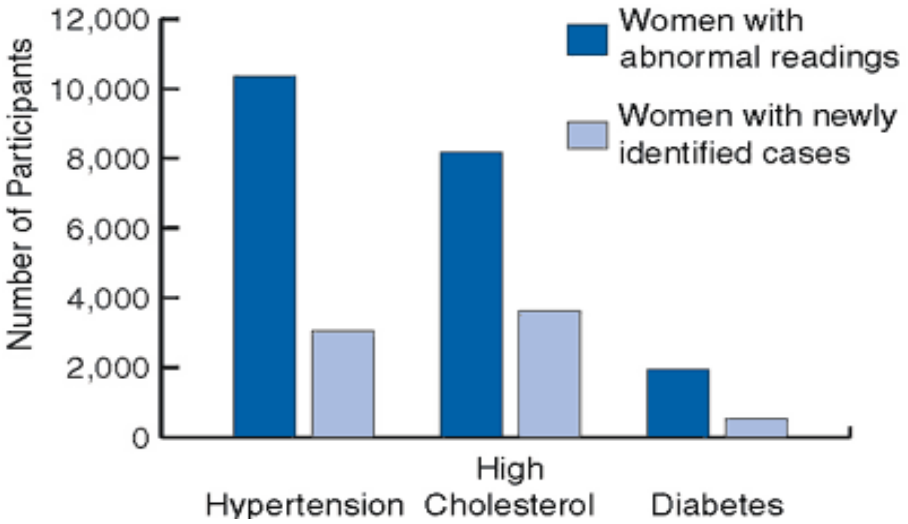
All Women Count! Chronic Disease Screening Program

by Jacy Clarke, Chronic Disease Epidemiologist

WISEWOMAN is a natural program funded by CDC to help uninsured and underinsured women gain access to screening and lifestyle interventions that can reduce their risk for heart disease and other chronic diseases. In South Dakota the program is called All Women Count! (AWC). According to the American Heart Association, cardiovascular disease (CVD), which includes heart disease, infarctions, and stroke, is the leading cause of death for women in the United States.

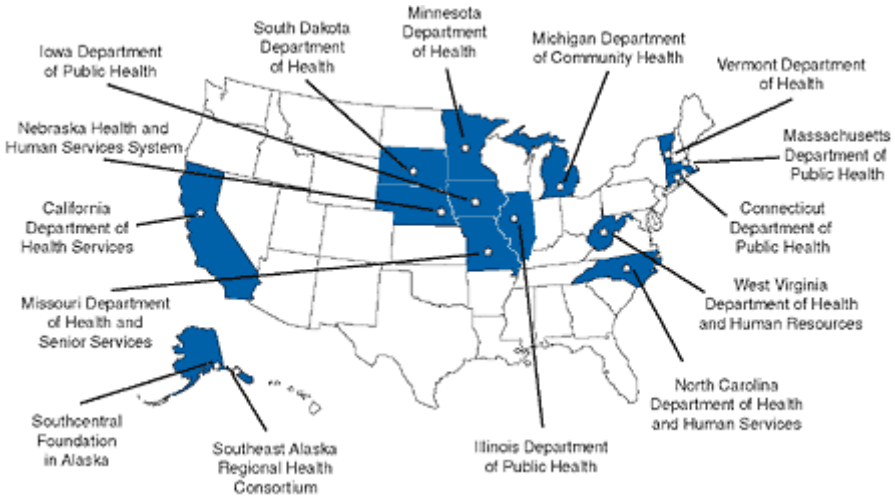
One in five women has some form of heart or blood vessel disease. In 2001, 931,100 people died from heart attacks and other coronary events; 498,900 (53.6%) of those victims were women. Cardiovascular disease is also a primary contributor to morbidity and decreased quality of life, especially among older women.

US WISEWOMEN Participants with Hypertension, High Cholesterol, and Diabetes January 2000 – June 2004



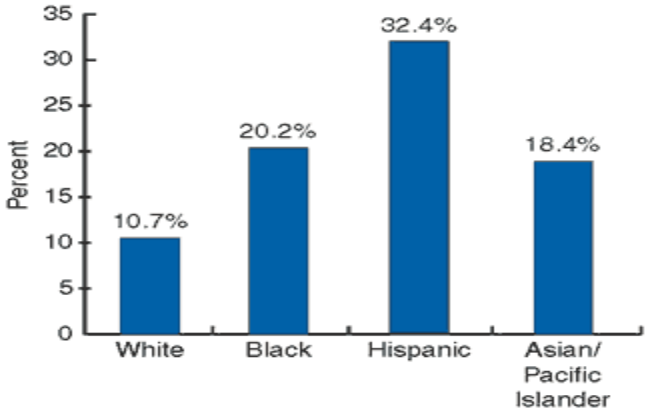
*Hypertension: n=29,256; 36% had abnormal readings.
Cholesterol: n=29,199; 28% had abnormal readings.
Diabetes: n=20,309; 10% had abnormal readings.
Source: WISEWOMAN Program, CDC.

In 2000 the All Women Count! breast and cervical cancer screening program was expanded to provide preventive services, including blood pressure and cholesterol testing, and lifestyle interventions to help women develop a healthier diet, increase physical activity, and quit using tobacco. Women not only are screened for cardiovascular disease and diabetes but also can be seen by a professional for four physical activity and nutrition sessions per year. The women receive incentives such as cookbooks, exercise bands, food scales, and exercise books when they attend the sessions. There are currently 173 provider sites statewide offering the expanded screenings. The program reimburses health care providers for screening, diagnosis, and patient education for diabetes and cardiovascular disease. Nationally, the program has grown to 15 projects in 14 states as of June 2004. In fiscal year 2004, the CDC received $14 million to fund WISEWOMAN projects throughout the United States.



Women in lower income brackets with lower levels of education and without health insurance have an increased risk of CVD morbidity and mortality, as do women from some racial and ethnic minority groups. Low-income, less educated, uninsured, and minority women have limited access to health services and are more likely to smoke cigarettes, to engage in limited physical activity, and to have poor nutrition .

Percentage of U.S. Adults Who Had No Health Insurance, by Race/Ethnicity, 2002



Source: U.S. Bureau of the Census. Health insurance coverage in the United States: 2002. *Current Population Reports*. September 2003:7.

The WISEWOMEN program offers a “best practices” framework that offers the opportunity to target other chronic diseases among women, including heart disease, the leading cause of death among women. The program also provides screening for additional chronic disease risk factors, dietary and physical activity interventions, as well as referral and follow-up as needed.

Rx Access

Rx Access helps women with alert levels of blood pressure, cholesterol and blood glucose access patient assistance programs that supply prescription medications at low or no cost. Rx Access provides access to drug companies' patient assistance programs for free or reduced-cost medication. While many screening sites already make this service available to patients in their clinic, those who need assistance in making the service available to their All Women Count! Chronic Disease Screening Program participants can work through the Department of Health. The program includes the services of a pharmacist who can consult with a participant's primary care provider if necessary. A woman may be eligible for Rx Access if she is enrolled in the All

Women Count program, has no prescription drug coverage through private insurance, does not qualify for any state assistance programs for prescription drugs, and has alert levels of blood pressure, cholesterol, or blood glucose.

South Dakota 2004 *All Women Count!* Project Summary

Number of Women Screened, SD All Women Count!, 2004					
Number of	**Historical: Oct 01-Dec 02**	**Year 2003: Jan-Dec**	**Year 2004: Jan-Dec**	**Total**	**CDC Minimum Standard/year***
Total Screenings	506	1,073	1,265	2,844	2,500
New Women Screened	503	964	993	2,460	.

Comments: The number of Total Screenings refers to the total number of cardiovascular risk factor screenings that have taken place. This number may include baseline screening and annual re-screening.

The number of New Women Screened refers to the number of women who have been screened through All Women Count! for cardiovascular disease (CVD) risk factors for the first time. At a minimum, participants are screened to determine if they have abnormal BMI, blood pressure, and cholesterol. Each woman is also asked health behavior questions to learn more about her diet, physical activity, and tobacco use.

*The minimum number of women that a project is to screen is determined by the type of project (standard or enhanced) and the funding level. The minimum number of women screened for enhanced (intervention research) projects is individualized and based on power calculations. Standard projects receiving level one funding are to screen a minimum of 500 women each year; projects receiving level two funding are to screen a minimum of 2,500 women each year.

Ages of Women Screened, SD All Women Count!, 2004			
Age Category	**Historical: Oct 01-Dec 02**	**Year 2003: Jan-Dec**	**Year 2004: Jan-Dec**
Age<30			0% (1/ 993)
Age 30-39	34% (169/ 503)	34% (332/ 964)	37% (365/ 993)
Age 40-49	35% (174/ 503)	36% (348/ 964)	35% (348/ 993)
Age 50-64	31% (158/ 503)	29% (284/ 964)	28% (277/ 993)
Age>=65	0% (2/ 503)		0% (2/ 993)

Comments: % refers to the percent of women with a baseline visit in the specified age category, the numerator is the number of women in the specified age category, the denominator is the total number of women with a baseline visit. All Women Count! services are provided to 40 to 64 year-old women who are enrolled in the state or tribal organization's BCCEDP. The WISEWOMAN Program has granted special permission to two projects (SD and SEARHC), which allows them to provide All Women Count! screening and intervention to women aged 30-64 years.

In 2003, there were a total of women screened, and in 2004, 2844 total screenings occurred. The mean age of All Women Count! participants is 52 years. All Women Count! services are provided to 40 to 64 year-old women who are enrolled in the state or tribal organization's Breast and Cervical Cancer Early Detection Program (BCCEDP). The WISEWOMEN Program has granted South Dakota special permission to provide All Women Count! screening and intervention to women aged 30-64 years.

Fifty-eight percent of women enrolled in the All Women Count*!* program are white non-Hispanic, 19% are black, non-Hispanic, 10% are Hispanic, and 11% are American Indian or

Alaska Native. Over 25% of the women have less than a high school education, 44% are high school graduates, and 31% have some college education.

Baseline Risk Profile

Risk Factors of Women Screened, SD All Women Count!			
Risk Factor	**Historical: Oct 01-Dec 02**	**Year 2003: Jan-Dec**	**Year 2004: Jan-Dec**
a) Pre-Hypertension (120/80-139/89)	35% (173/ 499)	34% (324/ 950)	31% (304/ 972)
b) Hypertension (>=140/90 or meds)	29% (145/ 499)	26% (251/ 950)	26% (255/ 972)
c) Borderline High Cholesterol (200-239)	30% (136/ 461)	32% (291/ 910)	28% (264/ 929)
d) High Cholesterol (>=240 or meds)	20% (94/ 461)	20% (186/ 910)	19% (180/ 929)
e) Pre-Diabetes (BG 100-125)*	14% (66/ 458)	17% (155/ 898)	17% (158/ 930)
f) Diabetes (BG>=126 or history or meds)	12% (54/ 458)	8% (74/ 898)	14% (130/ 930)
g) Smoking	40% (200/ 503)	37% (359/ 964)	34% (342/ 993)
h) Overweight (BMI 25-29.9)	25% (126/ 497)	32% (293/ 919)	30% (279/ 942)
i) Obese (BMI>=30)	47% (236/ 497)	45% (409/ 919)	42% (396/ 942)
j) None of the Above	5% (26/ 503)	4% (42/ 964)	6% (62/ 993)

Comments: % refers to the percent of women at baseline with a risk factor, the numerator is the number of women at baseline with a risk factor, the denominator is the total number of women at baseline with non-missing lab data.

*Pre-Diabetes is defined as a fasting blood glucose 100-125mg/dl or a non-fasting glucose 140-199 mg/dl. Diabetes is defined as a fasting blood glucose>=126mg/dl or a non-fasting glucose >=200 mg/dl or history of diabetes or taking medication for diabetes.

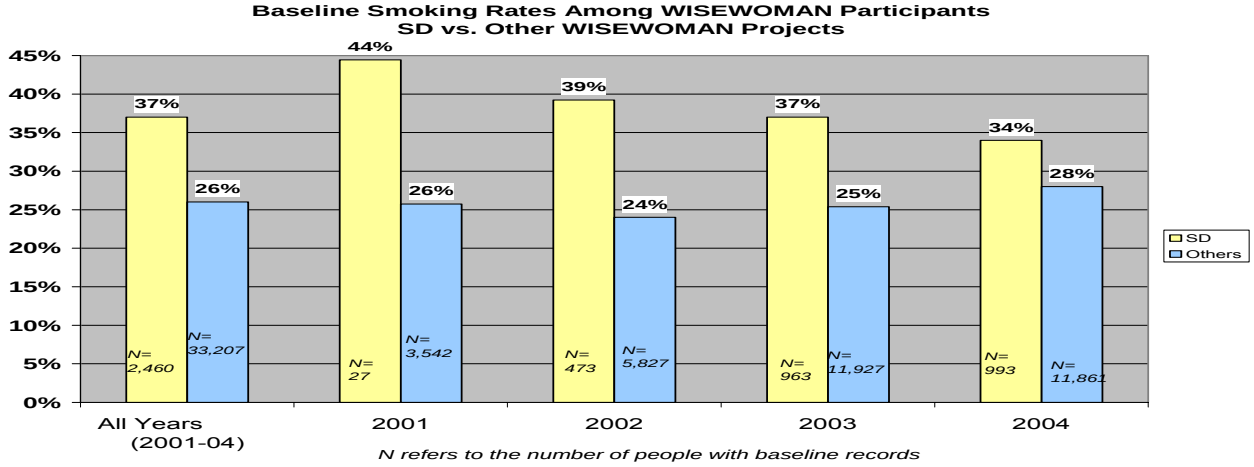
Program participants have a high baseline prevalence of CVD risk factors. Twenty-six percent of women have hypertension (defined as systolic blood pressure ≥140 mmHg or diastolic blood pressure ≥90 mmHg or reported taking medication for high blood pressure); 19% have high total cholesterol (defined as total cholesterol ≥240 mg/dl or reported taking medication for high cholesterol); and 14% have diabetes (defined as fasting blood glucose ≥126 mg/dl or non-fasting blood glucose ≥200 mg/dl or reported history of diabetes or taking medication for diabetes).

Newly Detected Cases of Hypertension, High Cholesterol & Diabetes, SD All Women Count!			
Risk Factor	**Historical: Oct01-Dec02**	**Year 2003: Jan-Dec**	**Year 2004: Jan-Dec**
Hypertension	24% (35/ 145)	25% (63/ 251)	20% (52/ 255)
High Cholesterol	50% (47/ 94)	55% (102/ 186)	44% (79/ 180)
Diabetes	15% (8/ 54)	16% (12/ 74)	39% (51/ 130)

Comments: % newly detected refers to the percent of women with a risk factor at baseline who state that they do not take medications for this condition, nor have they been told previously that they have this condition. The numerator is the number of women who state that they do not take medications for a specified condition, nor have they been told previously that they have this condition. The denominator is the total number of women at baseline with an abnormal reading for a specified measurement.

Intervention Session Attendance

Health promoting lifestyle interventions have been designed to provide All Women Count! participants with the knowledge, skills, and opportunities needed to improve diet, physical activity, and other life habits (like tobacco cessation counseling) to prevent, delay, or control CVD and other chronic diseases. To meet the CDC performance standard, 75% of women who have received CVD risk factor screening must attend at least one intervention session, and 60% must complete all intervention sessions. The following graphs illustrate the prevalence of CVD risk factors within the women enrolled in the All Women Count! program.



Percent Change From Baseline to Follow-up				
Factor	**Baseline Period: Jan 00-Dec 01**	**Baseline Period: Jan-Dec 02**	**Baseline Period: Jan-Dec 03**	**Baseline Period: All periods**
SBP	11.4	-1.4	-0.8	-0.9
DBP	-0.6	-2.7*	-1.0	-1.6*
TC	6.0	-0.7	-1.4	-1.1
BG	8.3	0.5	2.7	1.9
Weight	0.0	0.6	-0.4	0.0
Smoking	.	-4.8	-7.9	-6.8

*indicates statistically significant changes ($p<0.05$)
Comments: Changes in blood glucose are assessed for fasting blood glucose only.

SD All Women Count! Annual Re-Screens

Baseline Period	Re-Screened at 10-14 months	Re-Screened at 15-18 months	Re-Screened at 19-24 months	Re-Screened at >24 months
Jan-Dec 03	17% (163/ 964)	2% (24/ 964)	0% (3/ 964)	0% (0/ 964)
Jan-Dec 02	19% (91/ 476)	4% (21/ 476)	5% (24/ 476)	4% (17/ 476)
Jan-Dec 01	7% (2/ 27)	4% (1/ 27)	7% (2/ 27)	11% (3/ 27)
CDC Standard	75%			

Comments: % refers to the percent of women re-screened in the specified time period, the numerator is the number of women re-screened in the specified time period, the denominator is the total number of women screened during baseline period.

CVD screening results are collected each year to help determine if the ALL WOMEN COUNT! program is effective. Although national guidelines may indicate that a woman with a normal value does not need to be re-screened one year later (national clinical guidelines recommend that people with normal blood pressure return in 2 years; normal cholesterol, 5 years; normal glucose, 3 years), the ALL WOMEN COUNT! program requires annual screening to facilitate program evaluation. A minimum of 75% of all women initially screened will return for one annual re-screen per CDC performance indicator standard.

Changes In CHD/CVD Risk

Predicted Risk	Statistic	Baseline Period: Jan00 - Dec 01	Baseline Period: Jan-Dec 02	Baseline Period: Jan-Dec 03	Baseline Period: All periods
10yr CHD risk, Anderson	Baseline	3.6	4.2	4.7	4.5
	1yr Follow-Up	5.5	3.8	4.6	4.4
	% Change	54.1	-10.5*	-2.0	-4.2
	N	2	62	120	184
5yr CVD risk, Jackson	Baseline	1.3	2.5	2.9	2.7
	1yr Follow-Up	2.5	2.2	2.7	2.5
	% Change	100.0	-14.3	-6.5	-8.4
	N	2	62	120	184

*indicates statistically significant changes ($p<0.05$)

Comments: N refers to the number of women with a baseline screening in the specified time period who have completed 1-year follow-up and have non-missing data for all elements required to calculate the risk score.

Anderson's calculator estimates a 10-year probability of developing a coronary heart disease (CHD). Jackson's calculator estimates a 5-year probability of developing cardiovascular disease (which includes CHD and stroke, heart failure, and peripheral vascular disease). Both calculators use sex, age, systolic blood pressure, total cholesterol, high-density lipoprotein cholesterol, smoking, and diabetes status as input risk factors. Jackson's calculator also accounts for diastolic blood pressure.

Percent Change from Baseline to Follow-Up

Factor	Baseline Period: Jan00-Dec01	Baseline Period: Jan-Dec 02	Baseline Period: Jan-Dec 03	Baseline Period: All periods
SBP	11.4	-1.4	-0.8	-0.9
DBP	-0.6	-2.7*	-1.0	-1.6*
TC	6.0	-0.7	-1.4	-1.1
BG	8.3	0.5	2.7	1.9
Weight	0.0	0.6	-0.4	0.0
Smoking	.	-4.8	-7.9	-6.8

*indicates statistically significant changes ($p<0.05$)
Comments: Changes in blood glucose are assessed for fasting blood glucose only.

Alert Values

Period	Risk Factor	N with Alert	% Referred (N)	Mean Days From Screen to Referral (range)	% Seen (N)	Mean Days From Screen to Seen (range)	% Already on Meds (N)	% Prescribed Meds (N)
1). Year 2004 (Jan-Dec)	Blood Pressure (>180/110)	5	100% (5)	0(0, 0)	0% (0)	0(0, 0)	0% (0)	0% (0)
	Glucose (>375)	1	100% (1)	0(0, 0)	100% (1)	0(0, 0)	0% (0)	0% (0)
	Total Cholesterol (>400)	2	100% (2)	2(0, 3)	100% (2)	2(0, 3)	0% (0)	100% (2)
2). Year 2003 (Jan-Dec)	Blood Pressure (>180/110)	4	100% (4)	0(0, 1)	100% (4)	0(0, 1)	25% (1)	75% (3)
	Glucose (>375)	0	0% (0)	0(0, 0)	0% (0)	0(0, 0)	0% (0)	0% (0)
	Total Cholesterol (>400)	1	100% (1)	0(0, 0)	100% (1)	0(0, 0)	0% (0)	100% (1)
3). Historical (prior to Jan'03)	Blood Pressure (>180/110)	1	100% (1)	0(0, 0)	0% (0)	0(0, 0)	0% (0)	0% (0)
	Glucose (>375)	1	100% (1)	0(0, 0)	0% (0)	0(0, 0)	0% (0)	0% (0)
	Total Cholesterol (>400)	1	100% (1)	0(0, 0)	100% (1)	0(0, 0)	100% (1)	0% (0)
4). CDC Standard		.			95% (w/in 1 wk)			

Comments: % referred is out of those with an alert value, % seen is out of those referred, and % already prescribed med and % prescribed meds is out of those seen. All women who have an alert screening value will be evaluated immediately or within one week. The percent of women with an alert screening value who fail to follow through with the health care provider immediately or within one week will be no more than 5 percent.

Program Success Story: Helping Women Quit Smoking

In South Dakota, 42 percent of All Women Count! participants smoke tobacco, giving the program one of the highest smoking rates of all WISEWOMAN programs throughout the United States. The 259 All Women Count! Clinics are spread across the state. Many of the clinics are far from the nearest city and few, if any, can afford to hire a tobacco cessation specialist. The All Women Count! program in South Dakota offers one on one cessation counseling at the same place the women receive their health care. The program entitled "It's Time to Quit" is based upon the US Department of Health and Human Services (HHS) Treating Tobacco Use and Dependence: A Clinical Practice Guideline. The program recommends use of the five A's and five R's. The five A's include:

1. ask the woman if she is a chew tobacco user or smoker
2. assess how willing she is to quit
3. advise her to quit
4. assist her in quitting
5. arrange follow-up care for her

The five R's refer to motivation interventions for those unwilling to quit at the time. It gets smokers to identify the personal issues related to their tobacco use. The counselor helps the woman identify Relevance, Risks, and Rewards smoking holds for her, and the Roadblocks to quitting, all while using Repetition to reinforce a motivational message.

Whether or not the women receive counseling at the health clinic, they are told about the South Dakota QuitLine, where they can receive free counseling and Nicotine Replacement Therapy (NRT). The QuitLine covers 50% of NRT costs; the women are responsible for the other 50% of NRT costs. The most recent data regarding QuitLine usage among *All Women Count!* participants indicated from July 20, 2004- January 31, 2005, there were 38 program participants.

The All Women Count! Program is unique because it addresses multiple health needs of women by partnering with other CDC programs and by providing comprehensive interventions that help participants adopt healthier lifestyles. Partners such as CDC's Office on Smoking and Health, Division of Diabetes Translation, Division of Cancer Prevention and Control, and Division of Adult and Community Health provide guidance on ways to help women stop smoking, reduce their risk for heart disease and stroke, increase their physical activity levels, and improve their diet. The CDC has evaluated All Women Count! (WISEWOMAN) projects to learn which interventions work best. For more information about the program please call the All Women Count! Program at the South Dakota Department of Health 1-800-738-2301.

South Dakota Department of Health - Infectious Disease Surveillance

Selected Morbidity Report, 1 January – 30 September 2005 (provisional)

	Disease	2004 year-to-date	5-year median	Percent change
Vaccine-Preventable Diseases	Diphtheria	0	0	na
	Tetanus	0	0	na
	Pertussis	129	5	+2480%
	Poliomyelitis	0	0	na
	Measles	0	0	na
	Mumps	0	0	na
	Rubella	0	0	na
	Haemophilus influenza type b	0	1	-100%
Sexually Transmitted Infections and Blood-borne Diseases	HIV infection	30	17	+76%
	Hepatitis B	3	1	+200%
	Chlamydia	2067	1609	28+%
	Gonorrhea	263	209	26+%
	Genital Herpes	261	249	5+%
	Syphilis, primary & secondary	1	0	na
Tuberculosis	Tuberculosis	11	13	-15%
Invasive Bacterial Diseases	*Neisseria meningitidis*	3	2	+50%
	Invasive Group A *Streptococcus*	19	14	+36%
	Invasive Group B *Streptococcus*	16	10	+60%
Enteric Diseases	*E. coli* O157:H7	21	35	-40%
	Campylobacteriosis	214	145	+48%
	Salmonellosis	124	97	+28%
	Shigellosis	26	13	+100%
	Giardiasis	78	65	+20%
	Cryptosporidiosis	23	27	-15%
	Hepatitis A	0	2	-100%
Vector-borne Diseases	Animal Rabies (provided through July)	51	65	-22%
	Tularemia	7	5	+40%
	Rocky Mountain Spotted Fever	5	2	+150%
	Malaria (imported)	0	0	na
	Hantavirus Pulmonary Syndrome	2	0	na
	Lyme disease	0	0	na
	West Nile Virus disease	278	51	+445%
Other Diseases	*Streptococcus pneumoniae*, drug-resistant	3	3	+0%
	Legionellosis	10	3	+233%
	Additionally, the following diseases were reported: Bacterial Meningitis, non-meningococcal (17); Botulism, wound (1); Chicken pox (82); E. coli, shigatoxin-producing, non-0157:H7 (3); Hemolytic Uremic Syndrome (3); MRSA, invasive (34); *Staphylococcal* Toxic Shock Syndrome (1); *Streptococcal* Toxic Shock Syndrome (1); Q fever (1); Yersiniosis (1).			

Communicable diseases are obligatorily reportable by physicians, hospitals, laboratories, and institutions. The **Reportable Diseases List** is found at www.state.sd.us/doh/Disease/report.htm or upon request. Diseases are reportable by telephone, mail, fax, website or courier. **Telephones**: 24 hour answering device 1-800-592-1804; for a live person at any time call 1-800-592-1861; after hours emergency 605-280-4810. **Fax** 605-773-5509. **Mail** in a sealed envelope addressed to the DOH, Office of Disease Prevention, 615 E. 4th Street, Pierre, SD 57501, marked "Confidential Medical Report". **Secure website:** www.state.sd.us/doh/diseasereport.htm.

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